Mtn Home Spine & Health Solutions

Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ /_____ /_____ Social Security #: _____ - ____ - _____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? □ Yes □ No If yes, when: _____ /_____ /_____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe: _____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms.

When did these symptoms begin? _____ /_____ /_____ Are they: □ Constant □ Intermittent □ Activity-related Are

they getting worse? □ Yes □ No Do they interfere with: □ Work □ Sleep □ Hobbies □ Daily Routine

Explain: _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? □ Yes □ No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? □ Yes □ No

If yes, explain: _____

Have you been treated for this? □ Yes □ No When were you last treated? _____ /_____ /_____

Who did you see? _____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a Chiropractor before? □ Yes □ No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? □ Yes □ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? □ Yes □ No Did they recommend a Home Health Care program? □ Yes □ No

If yes, what? _____ How long were you treated? _____ Last treatment: _____/ _____/ _____

How did you respond? _____

Are you aware of any poor posture habits? □ Yes □ No Is there any history of spinal problems in your family? □ Yes □ No

If yes, explain: _____

_____

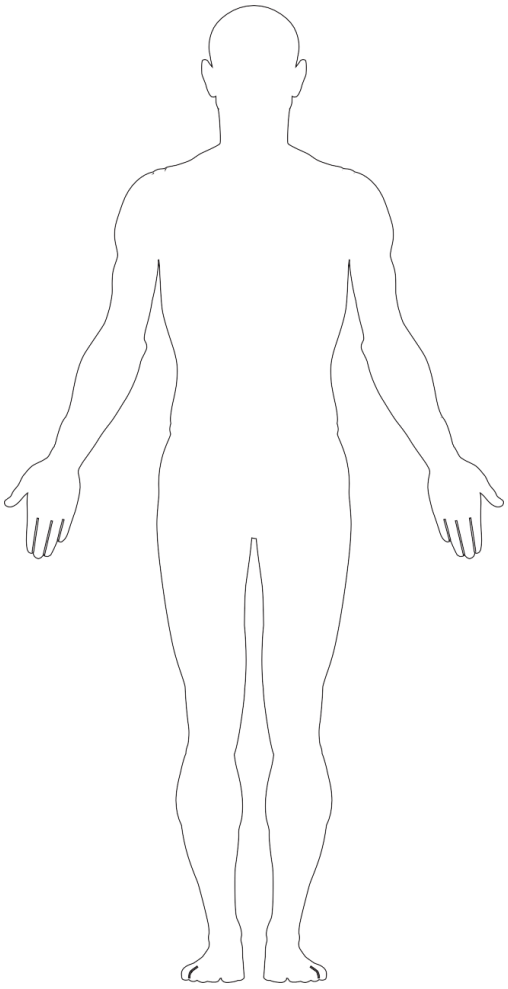
_____

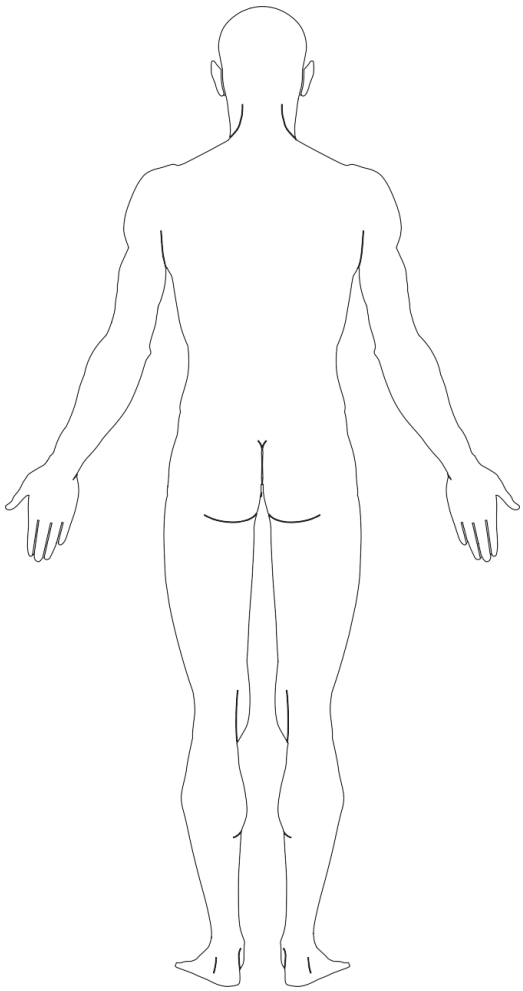
_____

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER





Health & Lifestyle

Do you exercise? □ Yes □ No How often? _____ day(s) per week; Other: _____

What activities? □ Walking □ Running/Jogging □ Weight Training □ Cycling □ Yoga □ Pilates □ Swimming □ Other: _____

Do you smoke? □ Yes □ No How much? / How often? _____

Do you drink alcohol? □ Yes □ No How much? / How often? _____

Do you drink coffee? □ Yes □ No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

CERVICAL SPINE (NECK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Heart Murmurs
____ Tachycardia
____ Heart Attacks/Angina
____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn/Reflux
____ Recurrent Lung Infection/Bronchitis
____ Asthma/Wheezing
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration
____ Nausea
____ Ulcers/Gastritis
____ Diabetes
____ Hypoglycemia/Hyperglycemia

LUMBAR SPINE (LOW BACK)

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Numbness/tingling in legs/feet
____ Frequent/difficulty urinating
____ Constipation/Diarrhea
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
____ Menstrual irregularities/cramping (females)
____ Low back pain
____ Coldness in legs/feet
____ Sexual dysfunction

OTHER

Please list any medications (include name, dose, for what condition, and how long you've been taking it): _____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed):_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: _____

_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ /_____ /_____

Patient's Signature _____ Date _____ /_____ /_____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine, or the spine of the charge I represent, through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date __ /_____ /_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature_____ Date _____ /_____ /_____

In Case of Emergency

Name _____ Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? □ Yes □ No

Patient's Signature _____ Date _____ /_____ /_____

Signature of Person Authorizing Care (if different from patient):

_____ Date _____ /_____ /_____

Relationship to Insured _____ Date of Birth _____ /_____ /_____

Employer _____

Primary Insurance Company_____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____

Secondary Insurance Company_____ Policy# _____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____ - ____ - _____